PRINTED: 08/04/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 150022 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1710 LAFAYETTE RD FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDSVILLE CRAWFORDSVILLE, IN47933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE A0000 A0000 Thank you for allowing us to This visit was for a PPS-excluded address the identified issues as psychiatric recertification. we work to improve services for our patients. Date of Survey: 07-21-11 Facility number: 005021 Surveyor: John Lee, R.N. Public Health Nurse Surveyor QA: claughlin 07/25/11 A9999 A9999 Neurological 08/31/2011 412.27(c)(1)(v) Distinct part psychiatric Examination: Responsible party: units: Additional requirements. A distinct Medical DirectorThe physicians part psychiatric unit must also meet the will begin to include in their following requirements: Maintain medical dictation. A template will be created to serve as a guide for records that permit determination of the minimum dictation elements degree and intensity of the treatment required. These will be provided provided to individuals who are furnished to the physicians, posted in services in the unit, and that meet the dictation areas, and used to create electronic templates where following requirements: Development of possible.Psychiatric Evaluation assessment/diagnostic data. Medical Intellectual records must stress the psychiatric Functioning:Responsible party: components of the record, including Medical DirectorThe physicians will begin to include in their

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

history of findings and treatment provided

for the psychiatric condition for which the

inpatient is treated in the unit. When

indicated, a complete neurological

TITLE

dictation. A template will be

minimum dictation elements

created to serve as a guide for

required. These will be provided

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 150022 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1710 LAFAYETTE RD FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDSVILLE CRAWFORDSVILLE, IN47933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE examination must be recorded at the time to the physicians, posted in dictation areas, and used to of admission physical examination. create electronic templates where possible.Psychiatric Evaluation -This rule is not met as evidenced by: Patient's Assets: Responsible party: Medical DirectorThe physicians will begin to include in Based on document review and interview, their dictation. A template will be the facility failed to ensure when created to serve as a guide for indicated, a complete neurological minimum dictation elements examination must be recorded at the time required. These will be provided to the physicians, posted in of the admission physical examination dictation areas, and used to for 5 of 5 medical records (MR) reviewed create electronic templates where (Patient #1, 2, 3, 4 and 5). possible.Inpatient Treatment Plans - Modality Responsibility: Responsible party: Findings include: Manager of Geripsych UnitThe treatment plan form will be 1. Review of patient #1's MR indicated modified to include the responsibility assignment for each the patient was admitted on 05-27-11 and modality.Director of Inpatient the MR lacked documentation of a Psychiatric Services Responsible neurological screening on admission to party: Executive DirectorDr. determine if a neurological examination Cobbs has assumed the role of was indicated. Medical Director for the psychiatric services. He is Board Certified. Medical Director review 2. Review of patient #2's MR indicated of quality and appropriateness of the patient was admitted on 05-08-11 and services:Responsible party: the MR lacked documentation of a Manager of Geripsych UnitThe Medical Director, unit manager neurological screening on admission to (or designee), and social determine if a neurological examination services will meet monthly to was indicated. review general reports, specific case issues, staffing, educational needs, and any other unit issues 3. Review of patient #3's MR indicated that may be of concern. Minutes the patient was admitted on 05-01-11 and will be generated for these the MR lacked documentation of a meetings and serve as 'proof' of neurological screening on admission to the Medical Director oversight/monitoring.Social determine if a neurological examination

		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		150022	B. WIN			07/21/2	U11
NAME OF	PROVIDER OR SUPPLIEF			1	ADDRESS, CITY, STATE, ZIP CODE		
			_	1	AFAYETTE RD		
FRANCI	SCAN STELIZABE	TH HEALTH - CRAWFORDSVILL	Ė	CRAWE	FORDSVILLE, IN47933		
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1 '	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
IAU	was indicated. 4. Review of pat the patient was a the MR lacked d neurological screed determine if a new as indicated. 5. Review of pat the patient was a the MR lacked d neurological screed determine if a new as indicated. 6. On 07-21-11 a confirmed that the out the results of assessments and 2, 3, 4 and 5's M. 7. Review of pat MR indicated it whether or not a examination was	ient #4's MR indicated dmitted on 04-23-11 and ocumentation of a sening on admission to surological examination ient #5's MR indicated dmitted on 04-20-11 and ocumentation of a sening on admission to surological examination at 1500 hours, staff #42 he physicians used to fill individual nerve none were in patient #1,		IAU	Services Care Oversight:Responsible party Manager of Geripsych UnitTl Social Services coordinator or review the quality and appropriateness of services attreatment as part of the more meeting with the Medical Dir Due to there being only one Social Services staff membe social services contact from partnering hospital will review work of our social services at least quarterly (random chart selection) and offer feedback improvement as/if needed.	ne will and thly ector. r, a a v the t	DATE
	412.27(c)(2)(vi)	Distinct part psychiatric					
		requirements. A distinct					
		unit must also meet the					
		ements: Maintain medical					
		nit determination of the					

005021

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	I DING	00	COMPL	ETED
	150022		A. BUILDING B. WING 00 07/21/2011				
		1	D. ((1)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	AFAYETTE RD		
FRANCIS	SCAN ST ELIZABE	TH HEALTH - CRAWFORDSVILL	E	1	FORDSVILLE, IN47933		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	degree and inten	sity of the treatment					
	provided to indiv	viduals who are furnished					
	services in the un	nit, and that meet the					
	following require	ements: Psychiatric					
		inpatient must receive a					
		uation that must estimate					
	intellectual funct						
	functioning and	· ·					
	Tunetioning and	orientation.					
	This rule is not r	net as evidenced by:					
	Based on docum	ent review and interview,					
		to ensure that each					
	1						
		sychiatric evaluation that					
	included estimat						
	_	of 5 medical records					
	(MR) reviewed ((Patient #1, 2, 3, 4 and 5).					
	Findings include	::					
	1. Review of pat	ient #1, 2, 3, 4 and 5's					
		mentation of estimated					
	intellectual funct						
		uation was completed.					
	psycinative evalu	and mus completed.					
	2. On 07-21-11 a	at 1500 hours, staff #42					
	confirmed that patient #1, 2, 3, 4 and 5's						
	1						
	MRs lacked documentation of estimated intellectual functioning in the psychiatric						
	evaluation.	doming in the psychiatric					
	evaluation.						
	410.07(.)(0)()						
		Distinct part psychiatric					
	units: Additional	l requirements. A distinct					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE S COMPL 07/21/2	ETED	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDSVILLE			ST 17	710 LA	DDRESS, CITY, STATE, ZIP CODE FAYETTE RD ORDSVILLE, IN47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PRE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	following require records that perm degree and intens provided to indiviservices in the ur following require evaluation. Each psychiatric evaluan inventory of the descriptive, not in the facility failed inpatient had a princluded an inventory assets for 5 of 5 in reviewed (Patient Findings included 1. Review of patition MR lacked document of the patient's assets as evaluation was confirmed that patient that patient had a patient had	tient #1, 2, 3, 4 and 5's mentation of an inventory ssets when the psychiatric completed. t 1500 hours, staff #42 mentation of an epatient #1, 2, 3, 4 and 5's mentation of an epatient's assets in the					

005021

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	NSTRUCTION 00		(X3) DATE S COMPLI 07/21/20	ETED	
		190022	B. WIN			_	07/21/20	J11
NAME OF PROVIDER OR SUPPLIER				1	DDRESS, CITY, STATE, Z	ZIP CODE		
				1	FAYETTE RD			
FRANCIS	SCAN STELIZABE	TH HEALTH - CRAWFORDSVI	LLE	CRAWF	ORDSVILLE, IN479	933		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN C			(X5)
PREFIX	` ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATI	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC	CY)		DATE
IAU	412.27(c)(3)(i) E units: Additional part psychiatric use following require records that perm degree and intemprovided to indiviservices in the unservices in	Distinct part psychiatric requirements. A distinct unit must also meet the ements: Maintain medical nit determination of the sity of the treatment viduals who are furnished nit, and that meet the ements: Treatment Plan. The treatment plan that must have an individual reatment plan that must inventory of the inpatient's tabilities. The written plan substantiated diagnosis; ong-term goals; the nt modalities utilized; the of each member of the		IAU				DATE
	Findings include	:						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	SLG211	Facility I	D: 005021	If continuation sh	eet Pac	ge 6 of 11

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO. ILDING	00	COMPI	LETED	
		150022	B. WIN	NG		07/21/2	2011
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDSVILLE			.E	1710 LA	DDRESS, CITY, STATE, ZIP CODE NFAYETTE RD CORDSVILLE, IN47933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	MR lacked documembers were retreatment modal patient's treatme 2. On 07-21-11 a confirmed that p MRs lacked documembers were retreatment.	at 1500 hours, staff #42 atient #1, 2, 3, 4 and 5's umentation of which staff esponsible for the ities identified in each					
	units: Additional part psychiatric following requirements in adequate number professional and evaluate inpatient individualized, or plans, provide and engage in diffollows: Director services; Medical psychiatric services supervision of a chief, or equival provide leadershipter intensive treatments.	supportive staff to nts, formulate written, comprehensive treatment ctive treatment measures scharge planning as r of inpatient psychiatric					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	150022		- 1	LDING	00	07/21/2	
100022			B. WIN		ADDRESS SITE STATE SID CODE	0172172	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	SCAN ST ELIZABET	ГН HEALTH - CRAWFORDSVILL	.E	1	FORDSVILLE, IN47933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	1 * *	nust be adequate to					
	l *	psychiatric services. The					
	clinical director,	•					
	1 -	meet the training and					
	1 ^ ^	rements for examination					
	l -	Board of Psychiatry and American Osteopathic					
		ogy and Psychiatry.					
	Dogra of Neurol	ogy and i sycillally.					
	This rule is not n	net as evidenced by:					
	Based on docum	ent review and interview,					
		to ensure that the					
	1	ient psychiatric services					
	met the training a						
		examination by the					
	1 ^	of Psychiatry and					
		Psychiatric Medical					
	Director (MD #1	_					
	Findings include	•					
	1. Review of MD	0 #1's credential and					
	privileging file la	acked documentation of					
	being board certi	fied by the American					
	· ·	atry and Neurology and					
		D #1 passed the written					
		the American Board of					
	Psychiatry and N	leurology in 1996.					
	2. On 07-21-11 a	t 1155 hours, staff #44					
	confirmed that M	ID #1 had 6 years after					
		en examination to					
		l examination for the					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	or conduction	150022	- 1	LDING	00	07/21/2	
100022			B. WIN		DDDESS CITY STATE ZID CODE	0772172	011
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	SCAN ST ELIZABET	ГН HEALTH - CRAWFORDSVILL	.E	1	FORDSVILLE, IN47933		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	πE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		of Psychiatry and					
	0,	ince MD #1 did not					
	1	l examination within 6					
	*	1 was considered no					
	~ ~	complete the American					
	l *	atry and Neurology board					
	certification.						
	412 27(4)(2)(;;) 1	Distinct part psychiatric					
		requirements. A distinct					
		init must also meet the					
	1 1 1	ements: Meet special staff					
	1 .	•					
	1 1	hat the unit must have					
	adequate number	-					
	1 ^	supportive staff to					
	1	ts, formulate written,					
		omprehensive treatment					
		tive treatment measures					
	"	scharge planning as					
		of inpatient psychiatric					
	services; Medica	-					
	1 ^ -	ces must be under the					
	1 *	clinical director, service					
		ent who is qualified to					
	1 ^	ip required for an					
		ent program. The number					
	_	s of doctors of medicine					
		nust be adequate to					
	l ~	psychiatric services. The					
		onitor and evaluate the					
		opriateness of services					
		ovided by the medical					
	staff.						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	NSTRUCTION 00	CC	ATE SURVEY OMPLETED 21/2011	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDSVILLE		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE NFAYETTE RD ORDSVILLE, IN47933			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	This rule is not n	net as evidenced by:					
	ensure that the D psychiatric service evaluated the qua- of services and to	ew the facility failed to irrector of inpatient ces monitored and ality and appropriateness reatment provided by the 1 inpatient mental health					
	Findings include	:					
	confirmed that the psychiatric service quality and appropriate and treatment pro-	t 1535 hours, staff #44 ne Director of inpatient ces was not reviewing the opriateness of services ovided by the medical tient mental health unit.					
	units: Additional part psychiatric u following require requirements in tadequate number professional and evaluate inpatien individualized, or plans, provide act and engage in disfollows: Social S	tinct part psychiatric requirements. A distinct anit must also meet the ements: Meet special staff hat the unit must have rs of qualified supportive staff to ts, formulate written, comprehensive treatment tive treatment measures scharge planning as tervices. There must be a services who monitors					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE : COMPL	ETED	
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NAME OF PROVIDER OR SUPPLIER			•	1	ADDRESS, CITY, STATE, ZIP CODE	•	
FRANCIS	SCAN ST ELIZARET	ГН HEALTH - CRAWFORDSVILL	F		AFAYETTE RD FORDSVILLE, IN47933		
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(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	and evaluates the	e quality and					
	appropriateness of	of social services					
	furnished. The se	ervices must be furnished					
	in accordance wi	th accepted standards of					
	•	blished policies and					
	procedures. Socia						
	•	nust include, but not					
		ipating in discharge					
		ing for follow-up care,					
		nechanisms for exchange					
		formation with sources					
	outside the hospi	tal.					
	This rule is not n	net as evidenced by:					
		ew, the facility failed to					
		rector of social services					
		valuated the quality and					
		of social services care					
	-	patient mental health					
	unit.						
	Findings include	:					
	 1	t 1535 hours, staff #44					
		ne director of social					
		reviewing the quality and					
		of services and treatment					
		al services for the					
	inpatient mental						